STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING _____ B. WING _____	02/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME INC	601 N BOEKE RD EVANSVILLE, IN 47711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: February 7, 8, 9, 10, 11, 14, 15, 16, 2011 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Survey Team: Diane Hancock, RN TC Sue Webster, RN Guylene Maurer, RD 2/7, 2/8, 2/9, 2/10, 2/11, 2/14, 2/15 Jodi Meyer, RN 2/7, 2/8, 2/9, 2/11, 2/14, 2/15, 2/16 Census bed type: SNF 30 NF 48 SNF/NF 115 Residential 9 Total 202 Census payor type: Medicare 28 Medicaid 124 Private 50 Total 202 Sample: 29 Supplemental sample: 5 Residential sample: 5 Supplemental sample: 2 These deficiencies also reflect state findings cited	F 000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of the regulatory required response and is not to be construed as agreement with the deficiencies cited. RECEIVED MAR 14 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

Approved SW 3/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peggy L Pixley	HFA	03/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 in accordance with 410 IAC 16.2. Quality review completed on February 23, 2011 by Bev Faulkner, RN	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	**F-157** Resident #93 continues to reside at the facility and has no skin impairments at this time. I respectfully request that the physician notification date stated on page 4, second paragraph of the statement of deficiencies be corrected to read 121210. To enhance currently compliant operations, under the direction of the Director of Nursing, by 031811, all licensed nursing staff will receive in-service training regarding state and federal requirements of F tag 157. The in-service will also include the facility's Practice Standard (exhibit A) regarding the necessity of notifying the resident, physician, and family member or legal representative. The Practice Standard will be signed by each licensed nurse. Because all residents have the potential to be affected by the cited deficiency, on 031111, the Director of Nursing developed a monitoring system regarding physician notification. The charge nurses will monitor the 24-hour report sheet (exhibit B) daily for events that require notification. Any identified residents' medical records will be reviewed by the charge nurses for	

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F 157	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician was notified of a change in condition, for 1 of 8 residents with pressure sores, in the sample of 29, in that the resident developed a pressure area and there was no evidence the physician was notified for 6 days. (Resident #93) Finding includes: During the initial tour, on 2/7/11 at 3:40 p.m., RN #2 identified Resident #93 as having an open area of her bottom. On 2/8/11 at 10:26 a.m., the clinical record for Resident # 93 was reviewed. The record contained diagnoses, including, but not limited to, failure to thrive, general debilitation, diabetes mellitus, anxiety and sacral ulcer. The most current Minimum Data Set [MDS] assessment, dated 12/31/10, identified the resident as requiring extensive assistance with bathing, transfers, eating, bowel and bladder incontinence, and indicated "yes" to having a pressure area. The record contained a skin assessment sheet, dated 12/6/10, that identified a "stage I, .75 cm [centimeter] X .75 cm with a depth of .10 cm. Small amount of serous drainage, pinkish white wound bed. The current treatment order was for Calmoseptine. The nurses' notes, dated 12/6/10 2200 [10:00 p.m.], described a small skin issue on the coccyx that measured .75 cm X .75 cm X .10 with a small	F 157	verification that the required notification has occurred and documented. Effective 031111, a quality assurance program was implemented under the supervision of the Director of Nursing to monitor physician notification. Designated management staff will be assigned to different units to review identified resident charts five times weekly for four weeks, three times weekly for four weeks, then one time weekly, ongoing. Any deficiencies will be corrected immediately. Results of the monitoring will be brought to the quarterly Quality Assurance Committee for further review, analysis, corrective action and recommendations as needed.	031811

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F 157	Continued From page 3 amount of serious fluid. On 12/12/10, the skin assessment sheet contained documentation that the area was a Stage 2, 1 cm X 1 cm no depth, no drainage with a red, black wound bed. The record lacked documentation of the physician being notified of the area until ~~12/12/11~~ 1530 [3:30 p.m.], when a new physician's telephone order was obtained to cleanse the area with normal saline and apply DuoDerm every three days and prn [as needed] dislodgement or soiled, until healed. On 2/10/11 at 9:50 a.m., the lack of physician notification at the time the area was found was reviewed with the ADON [Assistant Director of Nursing] and RN #2. RN #2 placed a call to the physician's office. RN #2 stated the office had stated they had "nothing earlier than 12/12/10." On 2/10/11 at 10:10 a.m., LPN #3, who had been the unit manager at the time, was queried about the lack of timely physician notification. She indicated she thought she had called or faxed the physician on 12/6/10. LPN #3 stated, "We had an order for the Calmoseptic and were using it. The area would close and reopen." On 2/15/11 at 12:50 p.m., the Director of Nursing Services provided the current copy of the physician notification policy dated 10/2010. The Policy Statement was as follows: "[facility name] shall promptly notify the attending physician and family of changes in the resident's medical/mental condition and/or status including physical, mental, cognitive, level of care, incidents/accidents, unusual occurrence, incidents involving	F 157	12/12/10 SNW 3/16/11	

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F 157	Continued From page 4 inappropriate behaviors, etc." The Policy Implementation section included, but was not limited to, "The staff nurse will notify the resident's attending physician or their designee when there has been: A need to alter the resident's medical treatment." 3.1-5(a)(3)	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were cared for in a manner that maintained their dignity and respect, for 5 of 29 sampled residents (#192, #182, #114, #113, #99) and 5 of 5 supplemental sample residents (#207, #190, #54, #76, #75), in that meal service was delayed for one resident, personal questions were asked in public, and signs regarding medical/nursing care were posted for anyone to see. Findings include: 1. On 2/15/11, Residents #192, #182 and #207 were seated at the same dining room table on the pavilion unit. Residents #192 and #182 were served their trays at 12:05 p.m. At 12:12 p.m., Resident #207 looked at both residents who were eating their food and said "I'm new, I guess I'm	F 241	**F-241** Resident #207 continues to reside at the Good Samaritan Home. Resident #207 was evaluated to determine the level of assistance needed at mealtime. The correct feeding assistance information was added to the C.N.A. assignment sheet. Resident #207 voiced no complaints of being inconvenienced at mealtime. Resident #190 had no adverse effect from the question asked by LPN #1. Residents #114, #113, #99, #54, #76, and #75 exhibited no adverse effects from having signs posted in their rooms regarding special care instructions and continue to reside at the facility. All care instruction signs were removed immediately from resident rooms. To enhance currently compliant operations, under the direction of the Director of Nursing, by 031811, all staff will be in-serviced on the state rule and federal regulation	

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F 241	Continued From page 5 not getting any food." At the same time, the FSS [Food Service Supervisor] was overheard asking the dietary server if everyone was served in the dining room, the answer was "yes." CNA #6 walked by the table, no interaction with the residents was observed. CNA #6 indicated at 12:12 p.m., "Oh, no tray." A few seconds later, the CNA indicated the resident was "a feed." At 12:15 p.m., Resident #207 received her meal tray. CNA #7 was seated with the resident and was feeding her the meal. At 12:30 p.m., the resident was being fed by CNA #7, and conversing with the CNA. LPN #1 was observed to ask the resident if she could move her wheel chair so other residents could leave the dining room through the side entrance. The resident's wheel chair was pulled away from the table into the hall area for, so that residents in wheel chairs could pass by the table. She was then placed back to her table to continue her meal. CNA assignment records were provided by LPN #1 on 2/15/11 at 10:00 a.m. The resident was identified on the assignment records as alert and pleasantly confused, assist with all meals. 2. On 2/15/11 at 12:25 p.m., Resident #190 was observed to finish her meal and push away from the table, in the main dining room of the Pavilion unit. LPN #1 was overheard, from 30 feet away, to ask the resident in loud voice, "Do you need to go to the bathroom?" "Do you want to sit by the window?" The resident was then wheeled to the picture window area. 3. On 2/14/11 at 10:30 a.m., a sign was observed posted on the wall behind Resident #114's bed.	F 241	regarding caring for residents in a manner and environment that would maintain or enhance each resident's dignity and respect in full recognition of his or her individuality. The in-service will focus on addressing the resident's right to dignity and respect of individuality, especially with regard to delay in meal service, inconveniencing of a resident during mealtime, asking private questions in a common area, and the posting of care instructions in a resident's room. Specific care instructions will be placed in a CARE Notebook for each nursing unit/hall. Laundry notices will be placed on the inside of the closet door. Because all residents have the potential to be affected by the cited deficiency, under the direction of the Director of Nursing, a monitoring tool was developed for monitoring meals for potential delay of service, inconveniencing of residents during mealtime by asking them to relocate, and the asking of private questions in common areas. Each dining area will be monitored once daily at random times, 5 times weekly for four weeks, 3 times weekly for 4 weeks, then weekly on an ongoing basis. Any deficiencies will be corrected immediately. A monitoring tool was also developed to check resident rooms for	

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F 241	Continued From page 6 The sign indicated, "HOB [head of bed] at least 30 degrees at all times." The sign was there, even though the information was available on the CNA Assignment sheets, provided by the Unit Manager on 2/15/11 at 10:00 a.m. 4. On 2/15/11 at 8:40 a.m., a sign was observed taped to the wall above Resident #113's bed. The information on the sign was a Swallowing Guide, with specific instructions on feeding the resident. 5. On 2/14/11 at 3:10 p.m., a sign was observed posted above Resident #99's bed. The sign indicated the bed was supposed to be as close to 90 degrees as possible when eating. 6. On 2/8/11 at 11:45 a.m., Resident #54 was observed in her room lying in bed. On the wall behind the head of the bed was a handwritten sign that read "Do not use perineal no-rinse spray. Allergic to. Use baby wash for all care please." On the door leading into the bathroom was another sign that read, "Use only body wash for shower and bathing. Do not use no rinse perineal spray- Allergic Reaction." On 2/7/11 at 3:30 p.m., RN #2, the unit charge nurse, had provided the Certified Nursing Assistant [CNA] assignment sheet. The assignment sheet did not include the above instruction. On 2/15/11 at 10:40 a.m., the signs were reviewed with the ADON and RN #2. They indicated the signs had probably been put up by the resident's family. When the CNA assignment sheet was reviewed, the ADON and RN #2 were unaware the information had not been included	F 241	inappropriate signage. The rooms will be checked weekly for four weeks, then every other week for four weeks, then monthly ongoing. Any deficiencies will be corrected immediately. The monitoring results will be brought to the quarterly Quality Assurance meeting for further review, analysis, corrective action and recommendations as needed.	031811

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F 241	Continued From page 7 on the assignment sheet. 7. On 2/11/11 at 11:25 a.m., Resident #76's room was observed to contain a handwritten sign on the bulletin board that read, "Do not use (L) arm transfer resident with gait belt. He is not to raise (L) [left] arm above his head X two weeks. Per [physician's name]." On 2/15/11 at 10:30 a.m., the above sign was reviewed with the ADON and RN #2. Both nurses indicated they were unaware of who had placed the signs. RN #2 removed the sign from the bulletin board and indicated the information had been for a limited time and was not needed any longer. When the CNA assignment sheet was reviewed, at that time, the ADON and RN #2 were unaware the information had not been included on the assignment sheet. 8. On 2/14/11 at 3:05 p.m., Resident #75's room was observed to have a sign over the bed that read, "All CNAs Total Hip Precautions. Float heels from PT [physical therapy] dept." A second sign read, "pressure relieving pillow taller portion of pillow should be toward the foot of bed." When the signs were reviewed with the ADON and RN #2, on 2/15/11 at 10:30 a.m., the ADON indicated that the facility used plastic sleeves mounted to the wall above the beds to hold information in a folder. Residents #75 and #76's room lacked the plastic sleeve on the wall. 3.1-3(t)	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246	**F-246** Resident #93 continues to reside at The Good Samaritan Home.	

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F 246	Continued From page 8 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure each resident had a means to summon help, for 1 of 26 current residents in the sample of 29, in that the call light was out of reach. (#93) Finding includes: On 2/8/11 at 10:05 a.m., Resident #93 was observed lying in bed. The resident stated, "I want a drink of water" two times. The resident's call cord was observed draped over the light shade of the light on the overbed table and out of reach of the resident. The Director of Nursing Service [DNS] was in the hall and was summoned to the room. The DNS repositioned the call cord on the bed, within the resident's reach, but made no response. On 2/8/11 at 10:26 a.m., the clinical record for Resident #93 was reviewed. The record contained diagnoses including, but not limited to, failure to thrive, general debilitation, diabetes mellitus, anxiety and sacral ulcer. The most current Minimum Data Set [MDS], dated 12/31/10, identified the resident as requiring extensive assistance with bathing, transfers and eating, and having mood swings.	F 246	To enhance currently compliant operations, under the direction of the Director of Nursing by 031811, staff will receive in-service training on each resident's right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, with emphasis on call lights being within each reach. Because all residents are potentially affected by the cited deficiency, on 031111, the Director of Nursing developed a C.N.A. Completion form (exhibit C). Included on the completion form is an entry to monitor the call light being within reach of each resident. Each C.N.A will complete a form for every resident on their assignment, every shift, every day. The Charge Nurses on each unit will in turn monitor the completion sheets for accuracy daily. A "C.N.A. Observation of Care" tool (exhibit D) was also developed to monitor call light placement. This will be completed by the charge nurse and the staff development coordinator randomly on their units 5 times weekly for 4 weeks, then 3 times weekly for four weeks, and one time weekly on-going. On 031111, a quality assurance program was implemented under the supervision of the Director of	

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F 246	Continued From page 9 The care plan, dated 1/15/10, for "Potential for episodes for and hx [history] of anxiety or restlessness." contained the following updated intervention, dated 9/13/10: "Answer call light [with] in 3 mins [minutes] in order to [decrease] restlessness or anxiety." The care plan for the ADL [activity of daily living] self care deficit R/T [related to] inability to contained the following intervention: "call light within easy reach and encourage its use. On 2/10/11 at 9:29 a.m., Resident #93 was observed lying in bed. The call cord was not visible. The head of the bed was raised and the perimeter mattress was against the side rails. The call cord was located on the siderail behind the mattress near the head of the bed and out of reach of the resident. 3.1-3(v)(1)	F 246	Nursing to monitor call light placement. A "C.N.A. Observation of Care" tool (exhibit D) was also developed to monitor call light placement. This will be completed by the charge nurse and the staff development coordinator randomly on their units 5 times weekly for 4 weeks, then 3 times weekly for four weeks, and one time weekly on-going. The results of both monitoring systems will be brought to the Quality Assurance Committee for review, analysis, corrective action, and recommendations as needed.	031811
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 4 of 29 sampled residents (#184, #179, #191, #193), in that new residents with multiple issues,	F 250	**F-250** Resident #184 was discharged to home with hospice services. Resident #179 returned to the facility's Pathways unit where previously resided. Resident #191 was discharged to home with home health services and arranged sitters. Resident #193 continues to reside at the facility and receiving services. To enhance currently compliant operations, under the direction of	

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F 250	Continued From page 10 and residents with changes in conditions, failed to have Social Service assessments and interventions in a timely manner. Findings include: 1. Resident #184 was observed, on 2/7/11 at 3:10 p.m., to be in bed, with a gastrostomy feeding infusing at bedside. According to interview with LPN #1, at the time, the resident was admitted from the hospital 1 1/2 to 2 weeks ago. She had multiple pressure ulcers, a surgical wound from amputation of the right leg, a PICC line [an intravenous line to administer medications and/or fluids], a Foley catheter, was total care and non verbal. LPN #1 also indicated the resident had a second CVA [cerebrovascular accident, also known as stroke] while in the hospital. On 2/9/11 at 9:45 a.m., the clinical record of Resident #184 was reviewed. The admission date was 1/27/11. The record lacked any type of social service notes. The hospital history indicated the resident had been alert and verbal at home. Activities included use of the wheel chair and assisted in meal preparation with her family. The tube feeding was used 22 hours a day, turned off for two hours each morning for care. The resident was NPO [nothing by mouth]. The resident was observed, on 2/9/11 at 10:40 a.m., to be transferred from the bed to the recliner by a mechanical lift. The resident was then placed in front of the picture window near the nurse's station. A Speech Therapist was observed to work with the resident on 2/9/11 at 11:00 a.m. The resident	F 250	the administrator, the social workers were in-serviced on the state rule and federal regulation stating the facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, with emphasis on new residents with multiple issues, residents with changes in conditions, and completion of assessments and interventions in a timely manner. Advance Directives will also be discussed to document reasons for changes in residents' code status and any dialogue with the resident or legal representative leading up to the change. Palliative and end of life support and comfort measures were included in the in-service. The Social Services documentation policy was changed to include a Social Services admission note to be written within 72 hours of a new resident entering the facility. The note is to reflect involvement with resident care in regards to psychosocial, mental, and physical well being. The 24 hour nursing shift report will be reviewed by Social Services every day, Monday through Friday, to capture any condition changes requiring potential assessments and documentation. Because all residents have the potential to be affected by the cited	

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	155716	A. BUILDING _____ B. WING _____	02/16/2011

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F 250	Continued From page 11 opened her eyes and looked sided to side; she did not open mouth, and participated very little. On 2/14/11 at 7:10 a.m., the Physical Therapist Assistant #1 was observed to perform the dressing changes to the left heel, coccyx area and debridement of the left hip. The gaping surgical wound to right stump was evaluated by the therapist at that time. The resident's daughter was interviewed on 2/7/11 at 12:10 p.m., and indicated that she would like to take her Mother home when she was stable. There was no indication social services had been involved in the care of the resident to date. 2. Resident #179 was observed, on 2/7/11 at 2:50 p.m., to have a large bruise over the left side of her face, from the top of her head to chin area. According to interview with LPN #1, during the initial tour at that time, the resident had fallen in her room when attempting to self toilet. LPN #1 indicated the resident had been admitted from the hospital after a high temperature. She indicated the resident was normally housed on the Alzheimer's unit and would be transferred back to that unit after rehabilitation. Resident # 179's clinical record was reviewed on 2/8/11 at 10:40 a.m. The re-admission date was 1/21/11. The last social service note was dated 12/28/10, when the resident resided on the Alzheimer's unit, prior to the hospital stay, the transfer to another unit and the fall causing injury. The nurse's note recorded the fall, on 1/27/11 at	F 250	deficiency, a monitoring system was developed by the administrator. The system will involve the administrator/ designee reviewing the 24 hour shift report with social services, Monday through Friday, for four weeks to identify residents needing follow-up from social services. A list will be compiled daily, Monday through Friday, to assist in monitoring the follow-up. Also, new admissions will be added to the list to verify social services' documentation within 72 hours. Any deficiencies will be corrected immediately. Effective 031111, a quality assurance program was developed. The program will involve the administrator/ designee reviewing the 24 hour shift report with social services, Monday through Friday, for four weeks to identify residents needing follow-up from social services. A list will be compiled daily, Monday through Friday, to assist in monitoring the follow-up. Also, new admissions will be added to the list to verify social services' documentation within 72 hours. After the initial four weeks, the administrator will check the progress of Social Services by randomly checking documentation of residents listed on the 24 hour shift report 3 times weekly for four weeks, then weekly ongoing. The results will be brought to the	

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F 250	Continued From page 12 1530 [3:30 p.m.], chair sensor in place, up to bathroom, 3 cm [centimeter] knot on head. On 2/11/11, the clinical record was reviewed again, the social service notes had been updated as of 2/9/11. The notes did not include the fall, and/or bruising of the face. The resident was observed on 2/8/11 at 12:20 p.m., in the main dining room of the Pavilion unit. The resident's face remained bruised. The resident was observed on 2/14/11 at 11:25 a.m., the bruise remained to left side of face and head. 3. Resident #191's clinical record was reviewed on 2/14/11 at 1:30 p.m. The resident was admitted from the local hospital after a fall. She had previously lived at home with home care. The resident's advance directive was signed on 12/2/10 ar 1800 [6:00 p.m.] indicating, "Full resuscitative measures and no intubation." On 12/3/10 at 1330 [1:30 p.m.], a nurse's note indicated, "N.O. [new order] code status to be DNR [do not resuscitate]." A telephone order, dated 12/3/10, indicated, "Code Status to be DNR." Social service notes were reviewed. The first note was dated 12/8/10. The notes did not address the reason for the change of code status within 24 hours of admission, or the discussion leading up to the change. 4. Resident #193 was observed in bed, during the initial tour, on 2/7/11 at 3:20 p.m. LPN #1 indicated, at the time, the resident had been to the hospital recently and had refused hemodialysis.	F 250	deficiency, a monitoring system was developed by the administrator. The system will involve the administrator/ designee reviewing the 24 hour shift report with social services, Monday through Friday, for four weeks to identify residents needing follow-up from social services. A list will be compiled daily, Monday through Friday, to assist in monitoring the follow-up. Also, new admissions will be added to the list to verify social services' documentation within 72 hours. Any deficiencies will be corrected immediately. Effective 031111, a quality assurance program was developed. The program will involve the administrator/ designee reviewing the 24 hour shift report with social services, Monday through Friday, for four weeks to identify residents needing follow-up from social services. A list will be compiled daily, Monday through Friday, to assist in monitoring the follow-up. Also, new admissions will be added to the list to verify social services' documentation within 72 hours. After the initial four weeks, the administrator will check the progress of Social Services by randomly checking documentation of residents listed on the 24 hour shift report 3 times weekly for four weeks, then weekly ongoing. The results will be brought to the	

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F 250	Continued From page 13 Resident #193's clinical record was reviewed on 2/9/11 at 3:00 p.m. The readmission date was 1/21/11. The hospital record "Renal" note, on 1/21/11, addressed the refusal of hemodialysis as follows: "Pt and family have decided not to do dialysis they are aware of consequences deterioration of health including death." The current record did not address the refusal or address the support and or comfort measures for the resident. The last social service note was dated 1/13/11, the date the resident was admitted to the local hospital, prior to the refusal of dialysis. The lack of social services was reviewed with the Director of Nurses, Assistant Director of Nurses and the Dementia Director, on 2/15/11 at 2:50 p.m, and the Administrator on 2/16/11 at 9:30 a.m. On 2/16/11 at 10:50 a.m., the Social Service Director provided care conference schedules for residents, but provided no information regarding interventions for the residents reviewed. On 2/16/11 at 3:25 p.m., the Administrator provided the Social Worker job description [no date]. "The Purpose" indicated, "The primary purpose of your job position is to assist in planning, developing, organizing, implementing,, evaluating, and directing social service programs in accordance with current existing federal, state, and local standards, as well as our established policies and procedures, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis."	F 250	quarterly Quality Assurance committee for review, analysis, corrective action, and recommendations as needed.	031811

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F 250	Continued From page 14 3.1-34(a)(1) 3.1-34(a)(2) 3.1-34(a)(4)	F 250		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced	F 272	**F 272** Resident #114 continues to reside at the Good Samaritan Home and pain is being controlled. To enhance currently compliant operations, under the direction of the Director of Nursing, the nursing staff will receive in-service training on pain assessments, understanding levels of pain, with emphasis on recognizing signs and symptoms of pain exhibited by non-verbal residents. A Practice standard (exhibit E-1) was developed for the nursing staff to further understand their role in reporting pain to the nurses and physician, assessing for causative factors, and evaluating the effectiveness of pain alleviating interventions. The C.N.A. Completion form will be used to assist with monitoring resident pain. The form (exhibit E-2) has an entry to mark for pain reporting. This information will be used to assist the Director of Nursing with monitoring pain management on non-verbal residents and residents who can self-report. Because all residents have the potential for being affected by the cited deficiency, the Director of	

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F 272	Continued From page 15 by: Based on observation, interview and record review, the facility failed to ensure 1 of 7 sampled residents reviewed for pain management, in the total sample of 29, was comprehensively assessed regarding the level of pain, in that assessments were not completed when resident was receiving care. (Resident #114) Finding includes: Resident #114 was observed during a bed bath and incontinence care, provided by CNA #1 on 2/14/11 at 10:30 a.m. The resident was observed to require total assistance for the bath and was observed to have upper and lower extremity contractures. Whenever the resident was turned, repositioned, and/or arms and legs stretched to provide the bath, the resident would moan and grimace. On 2/14/11 at 11:55 a.m., LPN #3 was interviewed. She indicated the resident had Lortab [pain medication] that could be given to her in the mornings prior to her morning care. CNA #1 was also interviewed with the nurse and indicated, "She was better this morning, usually she's louder." On 2/16/11 at 9:30 a.m., LPN #3 was interviewed. She indicated it seemed the pain medication had helped the resident and they had given it again that morning and had faxed the physician about getting something routine for pain management with Activities of Daily Living. She indicated when she had cared for the resident, providing medications through a gastrostomy tube, the resident had not shown signs of pain. "I guess the CNAs will need to be more vigilant in telling us	F 272	Nursing will compile a list of residents exhibiting pain symptoms. The Director of Nursing/designee will then check for accurate reporting of pain symptoms and to verify pain relief. This will be done on five residents weekly for 4 weeks, three residents weekly for 3 weeks, and one resident weekly ongoing. The results of the above monitoring will be brought to the quarterly Quality Assurance committee for further review, analysis, correction, and recommendations as needed.	031811

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F 272	Continued From page 16 if they are having pain with care," she stated. Resident #114's clinical record was reviewed on 2/9/11 at 2:45 p.m. The most recent quarterly Minimum Data Set Assessment, dated 1/14/11, failed to identify any pain issues. Other pain assessment forms in the record failed to indicate the resident had pain. There was no indication an assessment for pain had been completed when the resident was receiving care involving turning and repositioning, or having a bath. The policy and procedure for Pain Assessment, dated as reviewed February, 2010, was provided by the Director of Nurses on 2/15/11 at 12:50 p.m. The policy indicated assessments were to be performed at the time of admission, readmission, quarterly in conjunction with the MDS [Minimum Data Set Assessment] schedule, with change in diagnosis, and whenever the resident states or exhibits signs and symptoms of pain..." The procedure indicated, "When the resident is unable to communicate need, look for non-verbal signs/symptoms: moaning, crying, yelling, rocking back/forth, swearing, striking out, resisting care."	F 272		
F 282 SS=D	3.1-31(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F 282** Resident #69 and #185 continue to reside at the Facility. To enhance currently compliant operations, under the direction of the Director of Nursing by 031811, staff will receive in-service training. Such training will focus on the need for services provided or arranged by	

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F 282	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care in accordance with the written plan of care, for 2 of 29 sampled residents (#69, #185), in that gripper socks were not used to aid in fall prevention, and supplements were not provided, according to the care plan and physician's orders. Findings include: 1. On 2/7/11 at 3:05 p.m., Resident #69 was identified by RN#2 as being a fall risk, with a recent fall over the previous weekend. The clinical record was reviewed on 2/14/11 at 10:00 a.m. The record contained diagnoses that included, but were not limited to, dementia, history of bilateral knee surgery and osteoporosis. The most recent Minimum Data Set [MDS], a quarterly assessment, identified Resident #69 as being unable to ambulate and requiring extensive assistance for transfers. The care plan, dated 10/9/09, identified the resident had a fall on 12/9/10 and a new intervention for the use of non-slip socks was implemented. On 2/14/11 at 11:42 a.m., two certified nursing assistants were observed transferring Resident #69 from bed to a reclining geri chair. The resident was lifted and did not bear any weight. Resident #69 was wearing white socks without gripper strips on them. On 2/15/11 at 10:17 a.m., the observation was reviewed with the ADON [Assistant Director of	F 282	the facility must be provided by qualified persons in accordance with each resident's plan of care, with emphasis on following fall prevention interventions and receiving supplements as ordered by the physician. Because each resident has the potential to be affected by the cited deficiency care plans, interventions for fall prevention will be reviewed, and any additions or corrections will be added to the plan of care. The interventions will be added to the C.N.A. assignment sheets and high risk for falls for review of assessments for accuracy, care plans, and assistive devices. The Dietary Services Manager will review the medical records of residents receiving supplements to check that physician orders are present for the supplements. Nursing staff will be notified by the Dietary Services of any orders that need to be obtained and corrections made immediately. Effective 031111, a quality assurance program was implemented under the supervision of the Director of Nursing. The Director or Nursing/designee will perform the following systematic changes: random weekly checking for four weeks of five residents at high risk for falls to ensure the appropriate fall interventions are being followed, three residents at	

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F 282	Continued From page 18 Nurses] and RN#2. At that time, the resident was observed in bed in her room. RN #2 removed the cover from Resident #69 and when queried, stated, "no non-slip socks in place." 2. Resident #185's clinical record was reviewed on 2/14/10 at 8:10 a.m. The resident's progress notes from the Food Service supervisor, dated 2/7/11, recommended 2 Cal 60 cc TID [three times a day] between meals and Magic cup at supper. The Minimum Data Set Assessment [MDS], dated 12/17/10, recorded the resident as having weight loss. The medication administration record recorded, starting on 2/8/11, indicated the use of 2 Cal 60 cc, three times a day and Magic cup at supper. There was no physician's order for the supplements. A supper observation was completed, on 2/15/11 at 5:00 p.m.; the resident did not receive a Magic cup. The Administrator indicated, during interview on 2/16/11 at 9:30 a.m., there should be physician's orders for supplements and they should receive them as ordered.	F 282	high risk weekly for four weeks, then one weekly on-going. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be documented and submitted to the committee for review, analysis, correction and recommendations as needed. The Dietary Services Manager developed a quality assurance program for supplements. The list of residents receiving supplements will be checked for physician orders 1 time weekly for four weeks, then all new supplement requests will be checked to verify the physician's order. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be documented and submitted to the committee for review, analysis, correction and recommendations as needed.	031811
F 309 SS=G	3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F 309** Resident #114 continues to reside at the facility and receive services for pain management. Resident #185 continues to reside at the facility and receive services for pain management. To enhance currently compliant operations, under the direction of the Director of Nursing, the nursing	

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F 309	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide pain assessment and management, for 2 of 7 sampled residents reviewed for pain, in the total sample of 29, in that a resident experienced pain during Activities of Daily Living without intervention, and a resident was made to wait over an hour for requested pain medication, resulting in pain rated at a 10 [most severe] and refusal of therapy due to pain. (#114, #185) Findings include: 1. Resident #114 was observed during a bed bath and incontinence care, provided by CNA #1 on 2/14/11 at 10:30 a.m. The resident was observed to require total assistance for the bath and was observed to have upper and lower extremity contractures. Whenever the resident was turned, repositioned, and/or arms and legs stretched to provide the bath, the resident would moan and grimace. On 2/14/11 at 11:55 a.m., LPN #3 was interviewed. She indicated the resident had Lortab [pain medication] that could be given to her in the mornings prior to her morning care. CNA #1 was also interviewed with the nurse and indicated, "She was better this morning, usually she's louder." On 2/16/11 at 9:30 a.m., LPN #3 was interviewed. She indicated it seemed the pain medication had helped the resident, when given in the early morning 2/15/11, and they had given it again that	F 309	staff will receive in-service training on pain assessments, understanding levels of pain, with emphasis on recognizing signs and symptoms of pain exhibited by non-verbal residents. A Practice standard (exhibit E-1) was developed for the nursing staff to further understand their role in reporting pain to the nurses and physician, assessing for causative factors, and evaluating the effectiveness of pain alleviating interventions. The C.N.A. Completion form will be used to assist with monitoring resident pain. The form (exhibit E-2) has an entry to mark for pain reporting. This information will be used to assist the Director of Nursing with monitoring pain management on non-verbal residents. Because residents not having the ability to self report pain have the potential for being affected by the cited deficiency #1, the Director of Nursing will compile a list of residents exhibiting pain symptoms. The Director of Nursing/designee will then check for accurate reporting of pain symptoms and to verify pain relief. This will be done on five residents weekly for 4 weeks, three residents weekly for 3 weeks, and one resident weekly ongoing. The results of the above monitoring will be brought to the quarterly	

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F 309	Continued From page 20 morning and had faxed the physician about getting something routine for pain management with Activities of Daily Living. She indicated when she had cared for the resident, providing medications through a gastrostomy tube, the resident had not shown signs of pain. "I guess the CNAs will need to be more vigilant in telling us if they are having pain with care," she stated. Resident #114's clinical record was reviewed on 2/9/11 at 2:45 p.m. The most recent quarterly Minimum Data Set Assessment, dated 1/14/11, failed to identify any pain issues. There was no indication an assessment for pain had been completed when the resident was receiving care involving turning and repositioning, or having a bath. There was no care plan for pain management. The policy and procedure for Pain Management, dated as reviewed February, 2010, was provided by the Director of Nurses on 2/15/11 at 12:50 p.m. The policy and procedure indicated the following: "Residents who are unable to self-report [pain] due to age, level of consciousness, cognitive issues or other factors will be evaluated using behavioral or neurological responses. Behavioral responses include: altered body position, moaning, sighing, grimacing, crying, restlessness, muscle twitching, decreased activity, wincing, irritability, abnormal gait, failure to move an extremity, etc....Health care professionals should recognize that pain may not be accompanied by objective symptoms and complete the pain assessment form accordingly." "Patients who cannot self-report should have	F 309	Quality Assurance committee for further review, analysis, correction, and recommendations as needed. Because all residents have the potential to be affected by the cited deficiency #2, the Director of Nursing compiled a list of residents who can verbally report pain symptoms. Interview questions were developed to ask the residents about the timeliness of receiving pain medication and its effectiveness. The Director of Nursing/designee will interview 5 residents weekly for 4 weeks, then 3 residents weekly for 3 weeks, then 1 resident weekly ongoing. The results of this monitoring will be brought to the quarterly Quality Assurance committee for further review, analysis, correction and recommendations as needed.	031811

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	155716	A. BUILDING _____ B. WING _____	02/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 21 interventions based on assessment findings." "In the event a resident has a treatment which may cause pain, medication to be given should be administered 30-45 minutes prior to beginning the procedure." 2. Resident #185 was observed to receive his morning medication on 2/14/11. At 7:55 a.m., LPN #5 prepared the resident's medication. At 8:00 a.m., he received his medicine while in his room. At 8:15 a.m., LPN #5 indicated the resident wanted a pain pill; the LPN stated, "I'll just wait til after breakfast." At 8:35 a.m., LPN #5 prepared another resident's medications, while standing outside Resident #185's room. The resident stated from his room, "I need something for pain." LPN #5 stated, "I'll be with you, you will be next." From the time of 8:35 a.m. to 9:10 a.m., the therapy transporter was observed to approach Resident #185 four times for therapy; he was heard to instruct her that he was waiting on his pain medicine. The therapy transporter informed the nurse of the resident's need for pain medication, after the first interaction with the resident. The nurse informed the therapy transporter he [resident #185] would be next. At 9:10 a.m., the resident was overheard telling the therapy transporter, "I don't understand, having pain and suffering, and want something for it." At 9:10 a.m., LPN #5 questioned the resident	F 309		

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F 309	Continued From page 22 regarding rating his pain, he stated "10" [ten] the worst in his hip and foot. He requested the strongest pain pill he had ordered. At 9:15 a.m., Tramadol 50 mg [milligrams] one tablet was given by LPN #5. The physician's order was reviewed at 9:25 a.m. Tramadol 50 mg was ordered 12/20/10, "give 1-2 tablets orally 4 times a day as needed for pain." The last dose was recorded on 2/14/11 at 0045 [12:45 a.m.] for feet and toe pain. The resident's Minimum Data Set [MDS] assessment, dated 12/17/10, listed the following as the pain assessment: receives prn [as needed] pain medication, non medicated interventions for pain used, pain or hurting in last 5 days, frequently, hard to sleep at noc[night] due to pain, have limited day to day activity due to pain, moderate pain. 3.1-37(a)	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 16 sampled residents requiring assistance with incontinence care, in the total sample of 29,	F 312	**F 312** Residents #53 and #93 experienced no adverse effects from the cited deficient practice and continue to reside at the facility. To enhance currently compliant operations, under the direction of the Director of Nurses, by 031811, all nursing staff will receive training regarding dependent residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, emphasis on delivery of	

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F 312	Continued From page 23 received thorough assistance with personal hygiene following the incontinence, in that the entire area was not cleansed, or not cleansed well. (#53, #93) Findings include: 1. During the initial tour, on 2/7/11 at 2:40 p.m., Resident #53 was identified by RN #2 as being incontinent of bowel and bladder. On 2/8/11 at 11:45 a.m., the resident was observed being placed in bed prior to lunch, by two certified nursing assistants [CNAs] #3 and #4. Resident #53 had an incontinent brief in place. The brief was observed to be wet when it was removed. CNA #3 positioned the resident on the right side and proceeded to spray the peri wash on the resident's bottom. The CNA washed the buttocks and between the resident's legs with front to back strokes. A clean brief was then place under the resident and A & D ointment was applied to the area. The resident was placed on her back and the brief was tabbed in place. No cleaning had been done to the perineal area or the right hip. Pads were placed on the bed. The CNAs washed their hands and left the room. 2. On 2/11/11 at 11:40 a.m., CNA #2 was observed as she provided incontinence care to Resident #93, in preparation for the nurse to change a dressing on the resident's buttock. The CNA removed the resident's brief and proceeded to wash the resident's perineal area with a cloth of soap and water, rinsed the area, but not dried. The resident was then turned to the right side and the buttock area was washed from front to back. A clean brief was put under the	F 312	Incontinence care. The C.N.A.s will receive 1:1 pericare instruction from the Staff Development Nurse, the Infection Control Nurse and designees. Because all dependent for care residents have the potential to be affected by the cited deficient practice, the Director of Nursing compiled a list of residents to be observed during incontinence care. After the initial pericare instruction for C.N.A.s is completed by 031811, the Staff Development Nurse and the Infection Control nurse will monitor incontinence care through observation. Each nurse will do one random observation with one dependent for care resident, one time daily 5 times weekly for four weeks, then 3 times weekly for four weeks, then weekly ongoing. Any deficiencies will be corrected immediately. Effective 031811, a quality assurance program was initiated by the Director or Nursing. The Staff Development Nurse and the Infection Control nurse will monitor incontinence care through observation. Each nurse will do one random observation one time daily 5 times weekly for four weeks, then 3 times weekly for four weeks, then weekly ongoing. Any deficiencies will be corrected immediately. The findings will be brought to the	

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F 312	Continued From page 24 resident in preparation for the nurse's dressing change. On 2/11/11 at 11:52 a.m., LPN #4 came and changed the dressing. LPN #4 then applied Zovirax creme [used to treat to the rash, identified as a reoccurrence of genital herpes], on the resident's buttock and labia. LPN #4 then stated she wanted to apply some cream to the perineal area. When she looked at the area, she stated, "She's not clean enough." CNA #2 then rewashed the area to remove the old remaining cream, stating, "It's like plaster." 3. The policy and procedure for Perineal and Genital Care, no date, was provided by the Director of Nurses on 2/16/11 at 2:30 p.m. The policy and procedure included, but was not limited to, the following: "Policy: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode." "Procedure" "Wash hands and put on non-sterile gloves." "Assist the resident to lie on back and expose the perineal area." Soap one cloth at a time and wash genitalia using proper aseptic technique: a) Wash sides of labia first then groin areas. b) Rinse with remaining cloth using clean surfaces for all three surface areas (female). Do not place soiled soapy cloths back in clean basin water until procedure completed. c) Clean/rinse inner/upper thigh areas to remove urine moisture." "Assist resident to turn to side away from you."	F 312	quarterly Quality Assurance meeting for further review, analysis, corrective action, and recommendations as needed.	031811

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F 312	Continued From page 25 "Using the final rinse cloth from front washing, wash and rinse perianal area. Dry." "Assist resident to comfortable position. Empty basin, clean and dry. Place soiled cloths in linen hamper bag. Put soiled toilet tissues in commode." "Remove gloves and wash hands." 3.1-38(a)(3)(A)	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the facility failed to ensure the resident environment was free of hazards, for 2 of 7 nursing units (Pathways I, Pathways II), in that chemicals and tools were unlocked and unattended with potential for harm to the residents. This had the potential to affect 29 of 29 residents on the Pathways I unit and 4 of 21 residents residing on the Pathways II unit. (Residents #36, #42, #47, #45 of Pathways II). B. Based on observation, interview and record review, the facility failed to ensure assistive devices were in use, according to the plan of	F 323	**F-323** No residents were affected by this deficient practice. **A.1-2** All chemicals and tools listed in the statement of deficiencies have been removed and stored in secured areas. To enhance currently compliant operations, under the direction of the Director of Nursing, by 031811, all staff will receive in-service training regarding state and federal requirements for ensuring each resident is free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. All staff will be instructed on storage of chemicals and solutions in secured areas. Also, nursing staff will be in-serviced on using assistive devices according to the plan of care to prevent accidents. **A.1-2** Because all residents have the potential to be affected by the cited deficiency, the Director of	

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F 323	Continued From page 26 care, to prevent accidents, for 1 of 9 residents reviewed for falls, in the sample of 29, in that gripper socks were not in place and alarms/mats were not in place. (Resident #69) Findings include: A. 1. An unlocked, unattended, open area designated as the activity office, on the Pathways I locked dementia unit, had a cabinet with the door standing open, when observed on 2/15/11 at 11:15 a.m. The cabinet contained: a. A spray bottle of animal repellent with manufacturer's warning label stating "Hazards to humans and domestic animals. Causes eye irritation. First aid-hold eye open and rinse slowly and gently with water for 15 to 20 minutes. Call a poison control center or doctor for treatment." b. A spray bottle of "Seven" with manufacturer's label stating: "Harmful if swallowed or inhaled, if swallowed call a poison control center or doctor immediately for treatment advice." c. A spray can of "Clipperaide Spray" with manufacturer's label, "Causes skin irritation. Harmful if inhaled." d. A bottle of "Barbacide" with manufacturer's label stating "Danger corrosive. Causes irreversible eye and skin damage. Harmful if swallowed. Call poison control center." e. A can of New Image hair spray with manufacturer's label stating, "avoid spraying in eyes." f. A container of "Sani Hands" with manufacturer's label stating: "Do not use in contact with eyes." g. In unlocked draws in the desk area were: two screw drivers, nail clippers, metal cutters, two letter openers, pliers, four pairs of scissors, a	F 323	Compliance and the Director of Environmental Services developed a list of all storage areas (exhibit F). The storage areas will be checked for compliance daily 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly ongoing. Effective 031111, a quality assurance program was implemented under the supervision of the Director of Compliance. The storage areas will be checked daily 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly ongoing. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be documented and submitted to the quarterly Quality Assurance committee for review, analysis, correction and recommendations as needed. **B.1** Because each resident has the potential to be affected by the cited deficiency, care plan interventions for fall prevention will be reviewed, and any additions or corrections will be added to the plan of care. The interventions will then be added to the C.N.A. assignment sheets. Effective 031111, a quality assurance program was implemented under the supervision of the Director of Nursing. The Director or Nursing/designee will perform the following systematic changes: randomly checking, weekly	

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F 323	Continued From page 27 staple remover, wire cutting pliers, 38 bulletin board tacks. h. Two employee purses were setting on top of the work counter. Upon interview of Certified Activity Director #1 and Registered Nurse #1, at 11:30 a.m., on 2/15/11, both indicated the chemicals and hazardous items should not be accessible to the 29 dementia residents on the unit. They indicated all the residents were cognitively impaired. All the residents on the Pathways I unit were ambulatory. A.2. At 12:20 p.m. on 2/15/11, in the unlocked unattended nurses station on the Pathways II unit, a locked dementia unit with 21 residents, stored in drawers were the following items: a. A container of Sani Hands with manufacturer's label stating: "Do not use in contact with eyes." b. A tube of Hand Medic with manufacturer's label stating: "Keep out of eyes, if swallowed consult a physician or poison control center." c. a pair of nail clippers. d. Four screw drivers. During the initial tour, on 2/7/11 at 4:00 p.m., LPN #6 indicated four of the 21 residents were up ad lib on the unit: Residents #36, #42, #47, #45. B.1. On 2/7/11 at 3:05 p.m., during the initial tour, Resident #69 was identified by RN#2 as being a fall risk, with a recent fall over the previous weekend. The clinical record or Resident #69 was reviewed on 2/14/11 at 10:00 a.m. The record contained diagnoses including, but not limited to, dementia, history of bilateral knee surgery and osteoporosis. The most recent Minimum Data Set, a quarterly	F 323	for four weeks, five residents with fall interventions to ensure the appropriate measures are being followed, then three residents weekly for four weeks, then one weekly on-going. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be documented and submitted to the quarterly Quality Assurance committee for review, analysis, correction and recommendations as needed.	031811

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F 323	Continued From page 28 assessment, identified Resident #69 as being unable to ambulate and requiring extensive assistance for transfers. The care plan for high fall risk, dated 10/9/09, included interventions to keep the bed in the low position with a floor mat at bedside. The care plan had been updated to 2/7/11. The care plan identified the resident had a fall on 12/9/10, and a new intervention for the use of non-slip socks was implemented. On 2/4/11, a new intervention for the use of a floor sensor pad was added. The record contained documentation, on 2/3/11 1740 [5:40 p.m.] and 2/5/11 [no time], of the resident being observed on the floor beside her bed. On 2/14/11 at 11:42 a.m., two certified nursing assistants were observed transferring Resident #69 from bed to a reclining geri chair. The resident was lifted and did not bear any weight. Resident #69 was wearing white socks without gripper strips on them. On 2/15/11 at 10:17 a.m., the observation was reviewed with the ADON [Assistant Director of Nurses] and RN #2. At that time, the resident was observed in bed in her room. RN #2 removed the cover from Resident #69 and stated, "no non-slip socks in place." The floor sensor pad was underneath the bed and the floor mat was folded up and standing beside the bedside cabinet. 3.1-45(a)(1) 3.1-45(a)(2)	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	**F 441** It is the policy of this facility to maintain an infection control program to provide a safe,	

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F 441	Continued From page 29 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Residents #3, #93, and #114 experienced no adverse effects from the cited deficient practice and continue to reside at the facility. **A.1-2** To enhance currently compliant operations, under the direction of the Director of Nurses, by 031811, all nursing staff will receive training regarding appropriate hand hygiene and glove usage with emphasis on dressing changes and incontinence care. Because all residents have the potential to be affected by the alleged deficient practice, the Director of Nursing initiated a schedule to visualize direct care staffs' glove usage. The systematic change will be for the Infection Control nurse to check 5 different employees 5 times weekly, alternating shifts, for four weeks, to ensure direct care staff are using gloves correctly. After completion of the initial four weeks of monitoring, the Infection Control nurse will continue to randomly monitor 3 staff members weekly. This monitoring will be on-going. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be submitted to the quarterly Quality	

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F 441	Continued From page 30 by: A. Based on observation and record review, the facility failed to ensure staff washed their hands when indicated during dressing changes and/or incontinence care, for 2 of 16 residents reviewed for incontinence, in the sample of 29. (#93, #114) Gloves were not removed and/or handwashing/hand hygiene was not completed between clean and dirty tasks. B. Based on record review and interview, the facility failed to ensure the infection control program was implemented for 4 of 28 sampled residents who had orders for routine Mantoux skin tests for tuberculosis, in the sample of 29 (#157, #36, #116, #123), in that the annual tests were not completed at least annually and/or annual risk assessments were not completed. Findings include: A.1. On 2/9/11 at 9:50 a.m., RN #3 was observed doing a dressing change for an open area on the buttock of Resident #93. RN #3 was observed to remove a dressing, dated 2/8/11, from the area and proceeded to wash with soap and water, rinse, and dry the area. RN# 3 applied Bactroban to a small square of collagen dressing and covered it with a border dressing. The area of the resident's buttocks and labia were observed to be dark red with raised rough skin throughout the area. RN #3 indicated the area had been caused by a reoccurrence of genital herpes. The area was observed to have a residue of cream over it. RN#3 removed the cream residue, then applied Zovirax cream to her gloved hand and spread it over the area.	F 441	Assurance committee for further review, analysis, corrective action and/or recommendations. **B.1-4** Residents #157, #36, #116, and #123 were not affected by the cited deficient practice. To enhance currently compliant operations, by 031811, under the direction of the Director of Nursing, all nursing staff will receive training on the state rule and federal regulation requiring the infection control program be implemented for residents who have orders for routine Mantoux skin tests for tuberculosis, and that the annual tests are complete at least annually and/or annual risk assessments are completed. Because all residents have the potential to be affected by the cited deficiency, the Mantoux records of every resident were reviewed. All residents are now current with annual Mantouxs and/or risk assessments. Each resident's annual Mantoux and/or risk assessment is now being monitored by the Infection Control nurse. A monthly card system is being used and new residents added as needed. The Infection Control nurse will check the Medication Administration Record at the beginning and end of every month to ensure the monthly Mantouxs	

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F 441	Continued From page 31 CNA #5 was observed to reach toward the RN and was told, "Don't touch my hand." RN #3 then picked up the box that had contained the creme and placed the tube back into the box. She then laid the box back on the over the bed table. RN#3 then removed her gloves and, without any handwashing or alcohol gel use, applied a clean pair of gloves and repositioned the resident. When the observation was reviewed with RN #3 following the dressing change, her response was "Oh, ok." On 2/11/11 at 11:40 a.m., CNA #2 was observed as she provided incontinence care to Resident #93, in preparation for the nurse to change a dressing on the resident's buttock. The CNA donned gloves, removed the resident's brief and proceeded to wash the resident's perineal area with a cloth of soap and water, rinsed the area, but did not dry. The resident was then turned to the right side, the brief was removed, and the buttock area was washed from front to back. The CNA stated, "has kind of a raw butt." The CNA #2 then pulled the old dressing off of the open area and placed it in a wastebasket. CNA #2 then wet another clean washcloth, washed the entire area, placed the soiled linen in a barrel, put a clean brief under the resident, pulled the covers up over the resident, then removed her gloves. Without any handwashing or alcohol gel use, CNA #2 walked out into the hall to talk with the nurse, returned to the room, opened a drawer of the bedside cabinet and the	F 441	and/or monthly risk assessment are completed. The Infection Control Nurse will give a list of residents requiring a Mantoux or risk assessment each month to the appropriate charge nurse. A double check for dates and completion will also be done by each unit's charge nurse. Effective 031111, a quality assurance program was implemented under the supervision of the Director of Nursing. The Director or Nursing/designee will perform the following systematic changes: randomly checking, weekly for four weeks, five residents' Mantoux records for accuracy, then three residents for four weeks, then one weekly on-going. Any deficiencies will be corrected immediately, and the findings of the quality assurance checks will be documented and submitted to the committee for review, analysis, correction and/or recommendations as needed.	031811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING _____ B. WING _____	02/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 32 closet door. When the nurse entered the room at 11:52 a.m., CNA #2 donned a clean pair of gloves. Following the dressing change, the CNA removed a pillow from the bed, placed it in a chair at bedside, put pants on the resident, removed a pad from the bed, pulled the pants up and helped pull the resident up in the bed, put on a clean gown, removed the sheets and placed them in the hamper before removing her gloves and washing her hands. A. 2. On 2/14/11 at 10:30 a.m., CNA #1 was observed providing morning care to Resident #114. The resident had been incontinent of a large loose bowel movement. The CNA wore gloves and used the end of a towel, wet it, and applied peri-wash solution and cleansed the resident's peri-area. She folded and refolded the towel several times in the process of cleansing the feces from the resident. With the same gloves on, the CNA then reached behind her and handled clean underpads. She touched the resident's skin as she turned her to the side to place the clean pads under her. She rubbed her leg, and handled the clean sheet to cover the resident. She then took off the soiled gloves and washed her hands before proceeding to get a clean incontinence brief and clothes. The Director of Nurses provided the Handwashing/Hand Hygiene policy and procedure, dated February 2009, on 2/15/11 at 12:50 p.m. The policy and procedure included, but was not limited to, the following: "Employees must wash their hands for fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:	F 441		

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F 441	Continued From page 33 a. When hands are visibly dirty or soiled with blood or other body fluids; b. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; c. After handling items potentially contaminated with blood, body fluids, or secretions; and d. Before eating and after using a restroom." "If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications; e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care; g. After contact with a resident's intact skin; h. After handling used dressings, contaminated equipment, etc.; i. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; and j. After removing gloves." "The use of gloves does not replace handwashing/hand hygiene." B.1. Resident #157's clinical record was reviewed on 2/9/11 at 2:00 p.m. The last completed Mantoux skin test for tuberculosis [also known as PPD] was completed 2/27/09 and was read on 3/2/09 as 0.0 millimeters, indicating the resident was negative for tuberculosis. There.	F 441		

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F 441	Continued From page 34 was no indication of an annual risk assessment. B.2. Resident #36's clinical record was reviewed on 2/10/11 at 10:00 a.m. The resident's last completed PPD was dated as read on 5/6/09 and was 0.0 millimeters. There was no indication of an annual risk assessment. B.3. Resident #116's clinical record was reviewed on 2/9/11 at 9:40 a.m. The resident had a PPD test for tuberculosis, read on 10/17/09 as 0.0 millimeters. The next PPD was not completed until 1/28/11. There was no indication of an annual risk assessment. B.4. Resident #123's clinical record was reviewed on 2/14/11 at 1:55 p.m. The resident's last completed PPD test for tuberculosis was done 1/23/10 and read as 0.0 millimeters. There was no indication of an annual risk assessment. The Assistant Director of Nurses was interviewed on 2/16/11 at 1:20 p.m. She indicated Residents #157, #36, and #123 had no record of any further PPD testing. She indicated all three had PPD's administered 2/16/11 to update their records. She indicated Resident #116 went over a year between PPD tests for tuberculosis. The policy and procedure for Tuberculosis Screening, dated as revised April 2007, was provided by the Director of Nurses on 2/15/11 at 12:50 p.m. The policy for Serial Testing of Residents indicated the following: "a. The facility will conduct an annual risk assessment to determine TB risk classification (low or medium). b. If the risk classification is identified as 'low risk' for transmission of TB the facility shall screen	F 441		

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F 441	Continued From page 35 residents for TB if they develop symptoms of active TB disease or if there has been an incident of known exposure to a person with active TB. Otherwise, annual screening is not routine. c. If the risk classification is identified as 'medium risk' for transmission of TB, residents will receive an annual TST, with the exception of known 'converters.'" The facility's "Infection Control Guidelines," dated July 2010, was provided by the Director of Nurses on 2/15/11 at 12:50 p.m., and indicated surveillance would be completed to ensure residents were given yearly PPDs. 3.1-18(b)(1) 3.1-18(f)	F 441		

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R 000	INITIAL COMMENTS The following Residential Finding was cited in accordance with 410 IAC 16.2-5	R 000		
R 414	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. This RULE is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure hands were washed and/or sanitized between residents, for 1 of 2 LPNs observed administering medications (LPN #2) to 1 of 1 sampled resident, in the sample of 5 (#204), and 2 of 2 supplemental sample residents (#205, #199), in the supplemental sample of 2. Finding includes: LPN #2 was observed administering medications, on 2/15/11 at 4:35 p.m. She administered oral medications to Resident #205, and then proceeded to set up and administer oral medications to Resident #204 without washing her hands between the residents. Resident #204 complained of cramping and diarrhea at the time of the medication pass. LPN #2 obtained a stethoscope from the medication cart and listened to the resident's bowel sounds and obtained information from the resident about her symptoms. She then returned to the medication cart and proceeded to set up and administer oral medications to Resident #199. No hand hygiene was performed between residents.	R 414	**R 414** Residents #204, #205, and #199 were not affected by the cited deficient practice. To enhance currently compliant operations, under the direction of the Director of Nurses, all nursing staff will receive training regarding appropriate hand hygiene during medication pass. Because all residents have the potential to be affected by the alleged deficient practice, the Director of Nursing initiated a schedule to visualize handwashing/ sanitization during medication pass on the residential unit. The schedule consists of monitoring medication pass for at least three residents every day, random shifts, 4 times weekly for four weeks, then 2 times weekly for four weeks, then weekly ongoing. The monitoring will be done by the Director of Nursing/designee. Any corrections will be made immediately. The results of the monitoring will be brought to the quarterly Quality Assurance committee for further review, analysis, correction and recommendations as needed.	**031811**

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R 414	Continued From page 1 LPN #2 was interviewed at 5:00 p.m. She indicated she did not like to use the residents' sinks in their apartments to wash her hands, and that she usually used alcohol lotion, but had not done so. The policy and procedure for Handwashing/Hand Hygiene, dated as revised February 2009, was provided by the Director of Nurses on 2/15/11 at 12:50 p.m. The policy indicated the following: "This facility considers handwashing/hand hygiene as the primary means to prevent the spread of infections." "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." "Employees must wash their hands for fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...When hands are visibly dirty or soiled with blood or other body fluids.." "If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: "Before direct contact with residents." "Before preparing or handling medications" "After contact with a resident's intact skin." "After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident..."	R 414		